(2/01)

RETIRED MEMBER'S SOCIAL SECURITY NO: ___-___-____

FORM 6242

KENTUCKY RETIREMENT SYSTEMS
INSURANCE AGENT/COMPANY CERTIFICATION OF HEALTH INSURANCE
FOR HEALTH INSURANCE REIMBURSEMENT PLAN

Retiree's Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ ZIP Code _____

Telephone: (Home) _____ (Work) _____

Kentucky law provides for the reimbursement of hospital and medical insurance premiums for recipients of a retirement allowance who are not eligible for the same level of hospital and medical benefits as recipients living in Kentucky and having the same medical insurance eligibility status. The recipient shall be eligible for reimbursement of **substantiated** medical insurance premiums for an amount not to exceed the total monthly premium determined in **KRS 61.702 (3).** The retirement office will reimburse eligible recipients once each calendar year quarter. Pursuant to **105 KAR: 1:290** the following information is required to determine the retired member's eligibility for reimbursement under the medical insurance reimbursement plan.

I wish to be reimbursed for my medical insurance premiums. I hereby authorize the release of all pertinent medical insurance information to the Kentucky Retirement Systems for this purpose.

Signed: _____ Date: _____
(RETIREE)

TO BE COMPLETED BY AGENT OR AUTHORIZED REPRESENTATIVE OF INSURANCE COMPANY PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM. ALL QUESTIONS MUST BE ANSWERED IN ORDER FOR THIS FORM TO BE VALID.

Policy holder's name (if different from retiree): _____ Relation to Retiree:_____

Policy holder's Social Security Number (if different from retiree): _____

Medical Insurance Company: _____

Insurance Company's Address: _____

Insurance Co. Phone Number: _____ Policy Number: _____

Monthly Insurance premium: _____

Individuals covered under this policy:

Name	SSN	Relationship	Date of Birth	Effective Date of Coverage

RETIRED MEMBER'S SOCIAL SECURITY NO: ☐☐☐-☐☐-☐☐☐☐

Are the premiums paid in advance ☐, or in arrears ☐?
(KRS will not reimburse eligible members until the covered period has expired.)

IN ACCORDANCE WITH KRS 61.702 (7) THE KENTUCKY RETIREMENT SYSTEMS WILL REIMBURSE ELIGIBLE RECIPIENTS ON A QUARTERLY BASIS. PLEASE COMPLETE THE FOLLOWING PAYMENT HISTORY FOR THE APPLICABLE QUARTER:

1ST QUARTER	YEAR	PREMIUM OWED	PAID BY RETIREE	DATE PAID
January				
February				
March				

2nd QUARTER

April				
May				
June				

3RD QUARTER

July				
August				
September				

4th QUARTER

October				
November				
December				

I certify that all of the information completed on this form is true and accurate. I understand that there is penalty under Kentucky Law (KRS 523.100) for falsification of records.

Signature of Authorized Representative/ Agent: _____ Date:_____

Position Title: _____ Telephone #: _____

Name of Insurance Company/Agency: _____

Insurance Company's/Agent's Address: _____

_____

PLEASE RETURN THIS FORM TO:
KENTUCKY RETIREMENT SYSTEMS
1260 LOUISVILLE ROAD, FRANKFORT KY 40601
PLEASE CALL 800-928-4646 EXT 4520 WITH QUESTIONS